Elizabeth Hughes, MD — Health History Form (new visits)

NAME: _____ **DOB:** _____ **DATE:** _____

Allergies to medications and other items:

Name	Reaction
1.	
2.	
3.	
4.	

Dermatology History:

- ☐ Abnormal Moles
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Eczema
- ☐ Herpes or Cold Sores
- ☐ Hyperpigmentation
- ☐ Increased Hair Growth
- ☐ Hair loss
- ☐ Melanoma
- ☐ Nail Problems
- ☐ Psoriasis
- ☐ Shingles
- ☐ Thick Scars or Keloids
- ☐ Skin Cancer
- ☐ Other _____

Have you had blistering sunburns: No 1 or 2 More than 2

Personal Medical History:

Have you ever had a problem with the following? Check all which apply.

- ☐ Alcohol or substance abuse
- ☐ Blood
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestion, Inflammatory Bowel Disease
- ☐ Ears, Nose, Throat
- ☐ Emotional or Mental Health
- ☐ Eyes
- ☐ Heart or Blood Vessels
- ☐ Hepatitis
- ☐ Hormones (Thyroid, etc.)
- ☐ Kidney or Bladder
- ☐ Lungs
- ☐ Muscles, Joints, Bones
- ☐ Nerves and Brain
- ☐ Other _____

If yes, please explain: _____

_____

Please indicate if any of the following statements apply to you:

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial joints with in the last 2 years
- ☐ Artificial heart valves
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotics
- ☐ Needle phobia
- ☐ Taking blood thinners, including aspirin
- ☐ Currently pregnant or planning pregnancy
- ☐ Allergy to lidocaine
- ☐ Allergy to marcaine
- ☐ Rapid heartbeat to epinephrine
- ☐ Yeast infections with antibiotics
- ☐ Nausea or vomiting with antibiotics

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NAME: _____ **DOB:** _____ **DATE:** _____

Please list any surgeries or hospitalizations you have had, including skin surgery:

_____

_____

_____

_____

Do you (please circle the appropriate answer):

Use sunscreen	Daily	Occasionally	Never	
Use indoor tanning	Currently	Occasionally	Previously	Never
Drink alcohol	Daily	Socially	Rarely	Never
Smoke tobacco	Currently	Occasionally	Previously	Never
Use non-prescribed drugs	Currently	Occasionally	Previously	Never

Family Skin Disease History:
Have any family members had the following skin conditions

- ☐ Abnormal Moles
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Eczema
- ☐ Hyperpigmentation
- ☐ Increased Hair Growth
- ☐ Hair loss
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Thick Scars or Keloids
- ☐ Skin Cancer
- ☐ Other _____

If yes, please explain: _____

_____

Family Medical History:
Have any family members had illnesses of the:

- ☐ Blood
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestion
- ☐ Ears, Nose, Throat
- ☐ Emotional or Mental Health
- ☐ Eyes
- ☐ Heart or Blood Vessels
- ☐ Hormones (Thyroid, etc.)
- ☐ Kidney or Bladder
- ☐ Lungs
- ☐ Muscles, Joints, Bones
- ☐ Nerves and Brain
- ☐ Other: _____

If yes, please explain: _____

_____

_____